MONTANA
Department of Public Health & Human Services

Medicaid Billing Questions and Answers

These questions and answers are followed by a reference code:

- "F01.###" means the data was compiled from the provider training sessions Fall, 2001.
- "S02.###" are from the provider training sessions Spring, 2002.
- "F02.###" are from the provider training sessions Fall, 2002.

Please compare the date the question/answer was recorded with your date of service. Medicaid policy may have changed from an earlier date.

Medicaid Billing

Q. If the service a client is going to receive is not covered because the individual has "Basic" Medicaid, how should this be handled?

A. The provider should take a copy of the client's ID card and state to the client before rendering the service that the service is not covered under Basic Medicaid. A provider may bill a recipient for non-covered services if the provider has informed the recipient in advance that Medicaid will not cover the service and the recipient will be required to pay privately and the recipient has agreed to be a private pay patient. (F01.42)

Q. If someone shows us the Medicaid card for a previous month, telling us that they haven't gotten their new card in the mail, and claims submitted for their treatment come back denied for eligibility reasons, do we have to write off that treatment?

A. Yes. Payment for a patient's treatment can only be guaranteed if you see an updated card or obtain eligibility information through one of our eligibility verification methods. When a patient comes in for the first time, and does not have their updated Medicaid card, you can set them up as a private pay patient until they produce their Medicaid card. The easiest way to deal with a Medicaid patient who does not have an updated card is to simply use one of the eligibility verification methods immediately to determine their eligibility. If a patient is not eligible for Medicaid, providers can bill the individual as we would have no authority over a non-eligible person. (F01.43)

Q. Do you have to have a signed agreement between the provider and the patient when you give billing information or can it be given verbally?

A. A signed payment agreement between the provider and the client is not required by the Administrative Rules of Montana (ARM), but it is not a bad idea. Remember that the agreement cannot be a routine form that every client signs, but must be specific to a certain date and service. (F01.44)

Medicaid Billing (continued)

Q. Can we bill the patient for the leftover balance for a hospital stay after we have billed Blue Cross Blue Shield and Medicaid?
A. No, that is balance billing, and it is against the law. (F01.45)

Q. If a patient comes in for some sort of fertility treatment (which is not allowed under Medicaid), and Medicaid denies the service, can we bill the patient?
A. No, not unless the patient has been informed before the treatment that Medicaid may not pay for this service, and agrees that they will be responsible for payment. However, if this is an ancillary service from another provider (such as lab work requested from another provider), you have accepted that patient as a Medicaid patient for your services and cannot bill them after billing Medicaid. (F01.46)

Q. So, if you bill Medicaid, and Medicaid denies the charge for any reason, you cannot bill the patient?
A. You cannot bill the patient unless Medicaid denies because the patient is ineligible. In that case, you would be able to bill the patient. (F01.52)

Q. Our standard financial agreement with patients says that they are responsible for any charge not covered by their insurance company. Is this true for Medicaid patients as well?
A. If you do not tell the patient in advance that they are responsible and they do not agree to be a private pay patient in advance, you cannot bill the patient. (F01.53)

Q. What if a patient goes in as Medicaid but is ineligible – then you cannot bill them at all? Doesn't their ineligibility make the Medicaid rules null and void?
A. You can bill these patients, since they were never Medicaid patients to begin with. (F01.54)

Q. So, if a patient is not eligible, but we do not know they aren't eligible until after the treatment because they do not provide a card, we cannot charge them?
A. You can tell a patient who does not present a card that you are not willing to accept Medicaid for them until you have seen the card/ verified their eligibility. You will take them as a private pay patient until that time. If you do not see the card and choose not to verify eligibility through another method, you will be responsible for that patient's charges. (F01.55)

Q. How do you prove that you informed the client that they would be private pay?
A. Get it in writing, especially if it will only be for non-covered services or during an interruption in eligibility. (F01.57)

Medicaid Billing (continued)

Q. On our form for the patient to sign, determining their insurance, can we add a line that states the patient will be responsible if Medicaid won't cover the service or if the client is not eligible?

A. For a non-covered service, you cannot have a blanket form – it has to be specific as to the service that is not covered and what the patient will be expected to pay. You could create a blanket form stating that if the client is not eligible for Medicaid that they will be responsible for the bill. This is the case even if you do not have a form signed by the client. (F01.58)

Q. If an adjustment is showing on the Remittance Advice as being in a "Pended" status, should it be worked by the provider any differently than if it were a regular claim?

A. No, the provider should work the adjustment the same as a regular claim. Providers should keep in mind that an adjustment is basically the re-processing of the claim being adjusted. (F01.129)

Q. Do we need to include contractual adjustments on the claim form?

A. No. (F01.100)

Q. We have a problem with our local Hutterite colony. They delay paying their bills, because they say that we should bill Medicaid, and then Medicaid should bill them. They know that if they don't pay within 90 days, we have to bill Medicaid. How can we work this out?

A. Terry Frisch is the TPL Program Officer (406-444-4462), and he should be made aware of this problem. There is currently some research being done to resolve the colony problem, and there should be some sort of policy in the near future. It basically looks at each colony to see how they are set up legally. If you cannot legally separate the individual from the colony, then the individual could be eligible for Medicaid but we may deny based on TPL. Pharmacies do have a waiver for cost avoidance, so TPL can pay and chase on pharmacy claims. (F01.103)

Q. Can you take Medicaid off and make them private pay?

A. No. Not unless they have already agreed to be a private pay patient. (F01.163)

Q. Can you bill the patient if they will not sign the Medicaid release?

A. Yes, because they are not authorizing you to bill Medicaid. (F01.164)

Q. Is use of modifier "52" required for procedures less than 30 minutes long?

A. Use modifier "52" if services are not provided as normal. For example, if the provider has had to end a session because the patient is unable to continue, then modifier "52" would be appropriate to use. But do not use time only as a factor in choosing this modifier. (F01.174)

Q. What if you have only one diagnosis code?

A. Then just put one diagnosis pointer in 24 E, pointing back to that diagnosis. (F01.178)

Medicaid Billing (continued)

Q. We had a claim returned because the date was marked illegible, but we could read it clearly. What was the problem with the claim?
A. If the staff doesn't think that the microfilm machine will capture the date or other information, they send it back to be retyped. (F01.186)

Q. Shouldn't we be billing everyone the same standard rate – Medicaid, Medicare and other insurances?
A. Yes – you should use your usual and customary charge for Medicaid claims. (F01.191)

Q. If a provider has done a sterilization, and the recipient gets retroactive eligibility, can the provider bill Medicaid without the sterilization form?
A. Not without the correct form. If the provider suspects that the recipient may become eligible, then the provider should have the recipient sign the form prior to the sterilization. (F01.201)

Q. When do providers need to attach the one-day authorization form to the claim?
A. Attach the authorization form when the amount is different on the Remittance Advice than on the form and submit the claim to the ACS Provider Relations Unit for review. (F01.203)

Q. A recipient became retroactively eligible during their hospital stay. They were in the hospital on 5/30/01, but they were eligible for Medicaid on 6/1/01. Medicare requires dates of service from 5/30/01. How can the provider bill this?
A. They will have to prorate the stay for Medicaid eligibility both on the Medicare EOB and on the Medicaid claim. (F01.205)

Q. When you say bill the usual and customary charges, can we use Medicare charges as our usual and customary charges, or do we have to bill the amount we charge private pay clients?
A. Medicare charges are limited. If you charge Medicare one amount on their claim and then charge Medicaid a different amount on the same claim, it will deny. Medicaid uses that usual and customary charge amount to determine whether or not they will adjust fees in the future. (F01.211)

Q. Will it cause problems if I charge a Medicare/Medicaid client one amount and a strictly Medicaid client another amount for the same visit?
A. No, not in claims processing, but it may be a policy issue. (F01.212)

Billing on the UB-92

Q. What fields on the UB-92 should be used to indicate Medicare coinsurance and deductible if Form Locator 39 is used by the provider for something else?
A. The provider may also use Form Locators 40-41 to report that information. (F01.97)

Billing on the UB-92 (continued)

Q. Will UB-92's ever cross over?
A. We attended the Summit DataNet (renamed as Healtheweb) conference in Helena in October, and the woman speaking for Medicare Part A said that was on their priority list, but it's probably at least three years away. (F01.98)

Q. What do you put in the value codes amount?
A. You will record either the Medicare coinsurance or deductible in this box. (F01.195)

Billing on the CMS-1500 (Formerly HCFA-1500)

Q. On a HCFA-1500 form, can you use the same co-pay and deductible value codes as on the UB-92?
A. No. Value codes are specific to UB-92s. The equivalent fields are not on the HCFA-1500 claim form. (F01.124)

Q. Do deductibles and denials also cross over on HCFA-1500's?
A. Yes. (F01.126)

Q. Do you have to prepare a corrected HCFA form, or can you just work the changes noted?
A. No, you don't have to prepare a new, corrected HCFA form all the time. Changes can be made to the existing form. (F01.132)

Q. Where on the HCFA-1500 form do you put the PASSPORT provider number?
A. You can put the PASSPORT provider number in box 17A (ID number of referring physician). You don't have to have the name of the provider, only the provider number. (F01.170)

Q. If submitting a Medicare/Medicaid claim, does the provider need to enter the Medicare paid amount in Field 29 of the HCFA?
A. No, just attach the Medicare EOB to the claim form. (F01.172)

Q. What if you have only one diagnosis code?
A. Then just put one diagnosis pointer in 24 E, pointing back to that diagnosis. (F01.178)

Q. What if we have a new referring physician without a provider ID?
A. You can use their name on the form, we just prefer the ID if there is one. (F01.187)

Q. Do all diagnosis codes get keyed?
A. Yes, up to four diagnosis codes per claim on a HCFA-1500. (F01.189)

Q. What if there is a child who comes in for immunizations, and there are more immunizations than spaces for diagnoses?
A. You can make the diagnosis pointer point to whichever diagnosis you'd like for child immunizations – the diagnosis doesn't have to match the procedure in this case only. ACS can still only enter four diagnosis codes for the claim. (F01.190)

Billing on the CMS-1500 (continued)

Q. Should we put the CLIA number in box 24K?
A. No, it is not necessary. If you want to put a number for CLIA, it should be the Medicaid provider number. (F01.192)

Q. Can we correct our claims on the same form and resend?
A. Yes, as long as they are done legibly. (F01.193)

Q. In the amount paid box (29) on a HCFA-1500, do you have to put that amount for Medicare claims?
A. No. We do line level pricing for Medicare claims, and that's why we ask for the Medicare EOB. Also, don't put the co-pay amount in the other payment box, only put an amount there if it's truly a third party paying. (F01.210)

Q. I have a question about the diagnosis code pointer. We may have an Evaluation & Monitoring Procedure and a suturing code for the same visit. Will this cause the claim to deny?
A. As long as the procedure and the E&M are both supported by the diagnosis code you've chosen, you should not have any problems. (F01.213)

Electronic Billing

Q. Do payments come from Medicaid more quickly if we bill electronically?
A. Yes – a paper HCFA-1500 can take up to six weeks to show up on your Remittance Advice. But if you submit your HCFA-1500 electronically, it will show up on your Remittance Advice in about two weeks. (F01.99)

Q. On electronic claims submissions, is the date received the same as the date sent?
A. Electronic claims are submitted into our host and uploaded into the mainframe. Therefore, the date of receipt (Julian date on the ICN) will be the next business day following the transmission. (F01.177)

Q. How do you do multiple page claims electronically?
A. The electronic HCFA can take up to 21 lines on one claim. (F01.183)

Q. What is the receipt date for electronic HCFA's?
A. The receipt date is the date the HCFA is actually uploaded onto the mainframe. This is ordinarily the day after it is received except for weekends and holidays. (F01.184)